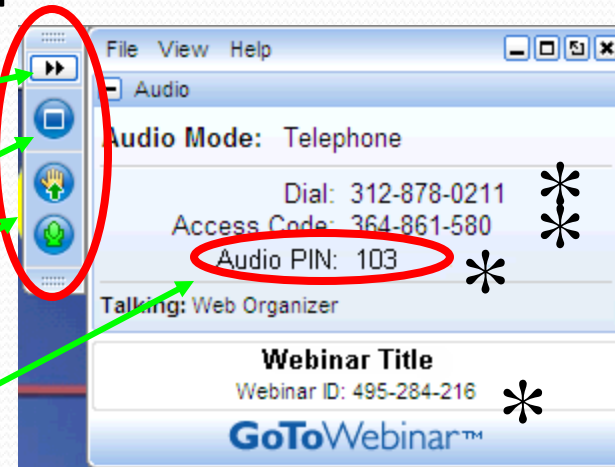# Using the Attendee Control Panel

- Grab Tab
  - Click arrow to open/close Control Panel.
  - Click square to toggle Viewer Window between full screen/window mode.
  - Click hand icon to raise/lower hand.
- **When joining via telephone, be sure to enter on the telephone keypad the Audio PIN noted in your Control Panel.**

- By default, you will be joined into the Webinar muted. Questions will be taken at the conclusion of the presentation.
  - Please use the Hand Icon to raise your hand to ask a question.
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Provider Billing Errors for BAYOU HEALTH Claims Submitted to Shared Savings Plans

Molina Medicaid Solutions

Community Health Solutions

United HealthCare Community Plan

Joint Training

Webinar #3

April 24, 2012

Bayou Health Implementation
A Transition from Legacy Medicaid to Medicaid Managed Care

This webinar is the third in a series of webinars addressing billing issues identified with claims

processed for Shared Health Plan members.

Reminders

- At the end of the presentation there will be a question and answer session. For this please make sure that you have dialed into the conference using your audio PIN and raise your electronic hand to ask questions. A red arrow means that your hand is up and the green arrow signals that your hand is down.

- There is a brief survey at the conclusion of this Webinar, Please take a moment to complete it as your feedback is vital for the preparation of the next Webinar.

Medicaid vs. Commercial Insurance Guidelines

DO NOT change your system to accommodate billing guidelines for commercial insurance.

- Bill claims as previously billed to Medicaid.
- Requirements have not changed for billing claims for Medicaid Recipients.

Examples of Identified Errors:

- NPI issues are of primary concern and continue to be a major issue.
  - Incorrect NPI submitted
  - NPI and Tie Breaker (taxonomy or zip code) not matching
  - Taxonomy/Zip Codes not included on claims where required
- Authorization Numbers (PA/Precertification) are Missing or Invalid causing 191 and 161 denials;
- Rehabilitation Centers and FQHCs entering attending provider numbers causing 202 denials.

Submitting Correct NPIs

- If claims are submitted to the Shared Plans with an NPI/NPIs that are <u>different</u> from those registered for the Medicaid provider number billing the services, the claims <u>are not processed.</u>

- The claims do not appear on a remittance advice because the billing NPI (or NPI/tie breaker combination) is not on the LA Medicaid provider file.

- This error continues to cause thousands of claims to fail for processing and final adjudication.

- Providers must ensure that correct NPIs/NPI and Tie Breaker (when applicable) are submitted.

- **Individual Providers who have both individual and organizational/business entity NPIs should <u>register both</u> NPIs with Molina Provider Enrollment.**

Verify NPI and Tie Breaker Code

- Registered NPIs and Tie Breakers (taxonomy or zip codes) can be verified on the secure side of www.lamedicaid.com

- Sign into the Provider logon link found on the home page

- Select NPI Legacy Search

- Enter either the 7-digit legacy Medicaid or 10-digit NPI number

- If there is a Tie Breaker code associated with your NPI it will be displayed under Value

- If there is no Tie Breaker code associated with your NPI the Tie Breaker and Value fields will be blank

- For electronic claims please refer to the electronic 837 Companion Guide for the correct loop/segment for NPI data.

NPI/Tie Breaker Cross Reference

Example of Medicaid Number Entered:

NPI/Tie Breaker Cross Reference

- Example of NPI Entered:

NPI/Tie Breaker Cross Reference

- Example of Zip Code as Tie Breaker

NPI/Tie Breaker Cross Reference

- Example of NPI without Tie Breaker Code needed:

<u>Only</u> LA Medicaid Enrolled Providers

- Providers billing claims for Shared Plan members MUST be enrolled as Louisiana Medicaid providers.

- Being contracted/affiliated with the Shared Plan for commercial business does not constitute a provider as being enrolled as a Louisiana Medicaid provider.

- Once enrolled, the NPI or NPI/tie breaker code combination registered with Medicaid <u>must</u> be used to bill claims for Medicaid members enrolled in Shared Plans.

- Claims submitted by non-Medicaid enrolled providers are not processed because the provider is not enrolled with Medicaid.

Providers and Their Contractors

- In circumstances where providers have billing vendors or use clearinghouses to transmit claims on their behalf, it is the provider's responsibility to:

  - ❖ Notify contractors that claims must be sent to the Shared Plans for recipients enrolled in Bayou Health Shared Plans.

  - ❖ These claims may not come directly to Molina if dates of service are on or after the Shared Plan effective date. We continue to identify many claims denied with edit 506 - SUBMIT TO RECIPIENTS SHARED PLAN

  - ❖ Notify contractors that Providers **must** submit claims with the NPI/NPI-tie breaker combination registered on the LA Medicaid provider file for that provider number AND contractors **can not** change this data.

  - ❖ Work with contractors to accomplish these requirements.

Authorizations

- Authorizations are still required on Facility claims as previously submitted to legacy Medicaid.

- We continue to see errors on claims submitted without authorization causing edit 161 and 191.
  - Edit 161 - HOSP STAY REQUIRES PRECERTIFICATION
  - Edit 191 - PROCEDURE REQUIRES PRIOR AUTHORIZATION

Example of services we continue to see needing authorization:

Revenue Codes: 350; 351; 352; 359; 610; 611; 612 or 614

(for radiology authorization of HCPCS 70000-79999)

Revenue Code 420 and Revenue Code 430

(for authorization of outpatient rehabilitation services)

Referral / Authorization Process Community Health Solutions

- Quick Reference: http://www.louisiana.chsamerica.com/index.php?id-34
- Applicable Definitions:
  - **Referral** – Written or verbal approval for a Member to seek and obtain services from a specialist or other provider when the PCP does not offer such service.
  - **Prior Authorization** – Written or verbal approval for a medically necessary service or procedure as defined by the Louisiana Medicaid State Plan.
- **Referral Policy**: A referral is required to see a specialist or another PCP outside of the practice/group to whom the Member is assigned. Members may be referred to and see any Medicaid enrolled specialists. The referral can be provided by the PCP or can be obtained by calling CHS at 855-CHS-LA4U (855-247-5248).
- **Prior Authorization Policy**: Refer to CHS website at http://www.louisiana.chsamerica.com/index.php?id=34 for the list of services and procedures that require Prior Authorization.

Referrals and Prior Authorizations Questions:
Care Management Department at 855-CHS-LA4U (855-247-5248)

Referral / Authorization Process UnitedHealthcare (UHC)

- Quick Reference: http://www.uhccommunityplan.com/assets/LA-PriorAuthorizationList.pdf
- Applicable Definitions
    - **Referral** is the directing of members for services or procedures to be provided by another provider, typically a specialist, when those services are outside the scope of service for the directing provider. Typically referrals are given by the member's primary care physician.
    - **Prior Authorization** is an approval from UnitedHealthcare for service or procedure for a member that is deemed medically necessary and meets the Louisiana Medicaid regulations as a covered service
- **Referral Policy**: Referral is not required for any covered service.
- **Prior Authorization Policy**: UnitedHealthcare requires prior authorizations for certain covered services. For a list of services that require prior authorization, refer to the Benefits and Prior Authorization Grid on page 10 of the Provider Manual and the quick reference link provided above. All physicians, facilities and agencies providing services that require prior authorization should call the Prior Authorization Department at 866-604-3267 (available 24/7), in advance of performing the procedure or providing service(s) to verify UnitedHealthcare has issued an authorization number.
- A Primary Care Physician or specialist can telephone or fax a prior authorization request to UnitedHealthcare Community Plan. A physician or pharmacist reviews all cases in which the care does not appear to meet criteria or guidelines which are adopted by UnitedHealthcare Community Plan's Medical Policy Committee. Decisions regarding coverage are based on the appropriateness of care and service and existence of coverage. Practitioners or other individuals are not rewarded, nor receive incentives for issuing denials of coverage or service.
- Responses to requests will be answered within two business days for standard requests, and within 72 hours for expedited requests.

Prior Authorization Questions:

Intake/Prior Authorization Team: Phone 866-604-3267 / Fax 877-271-6290 (Available 24/7)

Importance of Providing Molina with Current & Accurate Provider Information

- **It is the provider's responsibility to ensure that correct information is always present on the Medicaid provider file.**

- It is the provider's responsibility to ensure that the correct billing NPI is submitted on claims – which ensures that they are processed and appear on a remittance advice (RA).

- Providers that have chosen to use 1 NPI for multiple Medicaid provider numbers MUST ensure that the correct NPI/Tie Breaker combination is submitted for the correct Medicaid provider number.

Rehabilitation Center Claims

- Do not enter Attending Provider Numbers on Rehabilitation Center claims.

- Even when billing on the CMS-1500 claim form the attending provider number should be left blank.

- We continue to see Edit 202 on claims received.

Denial/Edit 202 – Provider Cannot Submit This Type Claim

Note: Rehab claims submitted directly to Molina for Non-Bayou Health recipients should continue to be billed on the state assigned form-102.

Common Denials

Denial/ Edit 209 – Group Must Bill for Provider

- Provider groups must continue to bill as a group and not as an individual physician(s).
- The group NPI that is on the Medicaid file should be entered as the billing number on the claim.
- The individual provider NPI that is on the Medicaid file should be entered as the attending provider number.

Claims should match the same format as previously billed to legacy Medicaid.

Common Denials

- **Denial/Edit 092 – Invalid Modifier**
  - The policy regarding modifiers for services rendered to a Medicaid recipient has not changed
  - Anesthesia claims should not be billed with the modifiers P1, P2, or P3 as these are not modifiers recognized by Louisiana Medicaid
  - Home Health claims should still be billed using the appropriate modifiers
  - A list of appropriate modifiers is available in the Professional Provider Manual from 2012 at www.lamedicaid.com

Common Denials

- **Denial/Edit 021 – Former Reference Number Missing or Invalid**

  - When submitting claim adjustments/voids make sure control number is entered into the correct field of the form or EDI transaction

  - As with Legacy Medicaid only a claim that has been paid can be adjusted or voided

Common Denials

Denial/Edit 217 – Recipient Name/Number Mismatch

- This denial occurs when the recipient's name or 13 digit Medicaid ID number does not match what is on file
- When editing for the name the system looks for the 1st 5 digits of the last name and the 1st digit of the first name

Denial/Edit 215 – Recipient Not on File

- Providers must verify eligibility through MEVS/REVS

Common Denials

We continue to see the following Denials/Edits:

- **Denial/Edit 273 – 3rd Party Carrier Code Missing/Invalid**

  - Medicaid policy has not changed with regard to TPL carrier codes needed on claims

- **Denial/Edit 299 – Procedure/Drug Not Covered by Medicaid**
- **Denial/Edit 232 – Procedure/Type of Service Not Covered by Program**

  - Policy and Fee Schedules found on www.lamedicaid.com.

Hospital
Revenue Codes Requiring HCPCS

251 – 257

259 – 269

278

300 – 359

370 – 444

450 – 636

730 – 761

790

820 – 929

Vision Service
Members Enrolled in a Shared Savings Health Plan

- For <u>eye wear</u>, continue to follow legacy Medicaid fee-for-service policy and requirements.

- When indicated Prior authorization can be obtained from the Molina Prior Authorization Unit at 1-800-488-6334; ePA www.lamedicaid.com; or Fax 225-929-6803.

- Claims for the <u>vision exam</u> and other <u>vision services</u> provided by an ophthalmologist, optometrist, or optician must be submitted to the patient's Health Plan for pre-processing and the Health Plan will then submit to Molina.

- Claims for eye wear shall continue to be billed and submitted directly to Molina as they were prior to Bayou Health.

Carved Out Services for Shared Plans

The following services continue to be billed to Molina

- Dental
- Pharmacy
- Waiver Services
- Durable Medical Equipment
- Long Term Personal Care Services
- Personal Care Services for Children under age 21
- Hospice

- Emergency and Non-Emergent Transportation Services
- Nursing Facility
- ICF-DD
- Case Management
- Adult Day Health Care
- EPSDT Health Services
- Early Steps case management and medical services

Current Billing Instructions

Please refer to the Medicaid website below for current billing instructions.

www.lamedicaid.com

Links:

- Provider Manuals

    or

- Billing information

Contact Information

Molina Medicaid Solutions
Provider Relations
800-473-2783
225-924-5040

UnitedHealthcare Community Plan of Louisiana, Inc.
Provider Relations
866-675-1607

Community Health Solutions of Louisiana
Provider Relations
855-247-5248

Questions